APPLICATION FOR REIMBURSEMENT FROM THE **COMPENSATION SUPPLEMENT FUND**

Michigan Department of Licensing and Regulatory Affairs Workers' Compensation Agency PO Box 30016, Lansing, MI 48909

☐ Initial (For Quarter)

| | | | | | | | ☐ Corrected | | |
|--|---|---|--|---|--|--|-----------------------------|--|--|
| (Type or print) | | | | | Carrier File No | ·. | | | |
| First, MI) | | | | | | | | | |
| | | | | | | | _ | | |
| Employee Street Address | | | | City | | | Zip Code | | |
| Social Security Number Date of Injury (MM-DD-YYYY) | | | | Average Weekly Wage on Date of Injury | | | Date of Birth (MM-DD-YYYY) | | |
| mpany or Self-Insured | I | | | | | Carrier I.D. Number | | | |
| Carrier Address (Street) | | | | City | | | Zip Code | | |
| Number | | | Quarter | Ca | alendar Year | Weekly Comp. Rate of | n Jan. 1, 1982 | | |
| Date to | Weeks | Days | | | Weekly Second Injury Fund Differential Benefits Paid | Weekly Compensation Supplement | Total Supplement Paid | | |
| | | | | | | | | | |
| | | | | | | Total Reimbursement Requested | | | |
| | | | | | | | | | |
| tion | | | | | | | | | |
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| | | | | | | | | | |
| Signature of Authorized Representative (In Ink) | | | | Name of Person to Whom Correspondence Should Be Sent (Please Print) | | | | | |
| Date of This Report | | | Address | | | Telephone Number | | | |
| which benefits are first paid. No se | | | led within three (3) months after the elubsequent reimbursements will be allo | | | Telephone Number nd of the calendar quarter | | | |
| Completion: Mandatory | | | | LARA is an equal opportunity employer/program. Auxiliary aids, services and other reasonable accommodations are available upon request to | | | | | |
| | Date to (MM-DD-YYYYY) I Representative (In In I | Date of Injury (MM-DD mpany or Self-Insured Date to (MM-DD-YYYYY) I Representative (In Ink) Provided the property of the provided that | Date of Injury (MM-DD-YYYY) mpany or Self-Insured Number Reimbursement Requested For: Injury (MM-DD-YYYY) Reimbursement Requested For: Injury (MM-DD-YYYY) Reimbursement Requested For: Injury (MM-DD-YYYYY) Reimbursement Reimbursement Requested For: Injury (MM-DD-YYYYY) Reimbursement Reimburseme | Date of Injury (MM-DD-YYYY) Number Reimbursement Requested For: Quarter On Paid Date to (MM-DD-YYYY) Date to (MM-DD-YYYY) Representative (In Ink) Name of Pers Address Address Initial form WC-114 must be filed within in benefits are first paid. No subsequent than one (1) year prior to the filing dates are Disability Compensation Act, 418.352; R408.32(2)(3) | Date of Injury (MM-DD-YYYY) Date of Injury (MM-DD-YYYY) | First, MI) ss City Date of Injury (MM-DD-YYYY) Average Weekly Wage on Date of Injury mpany or Self-Insured City Number Reimbursement Requested For: Quarter Calendar Year Calendar Year Calendar Year Calendar Year Fund Differential Benefits Paid Name of Person to Whom Correspondence Should Be Sent Address Address Initial form WC-114 must be filled within three (3) months after the en in benefits are first paid. No subsequent reimbursements will be allot than one (1) year prior to the filling date of the form WC-114. | Carrier File No. State | | |